MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4?

01439

CERTIFICATE OF DEATH

Reg. Dist. No. 3-5

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years 1 month
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 3.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Addie Hamblin Adkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Thomas E. Adkins
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1865

8. AGE:

Years	Months	Days	If less than one day
81	8	7	...hrs. ...min.

9. Birthplace Fairmont Md. (Town, county, and state)
10. Usual occupation Housework
11. Industry or business at home

FATHER
12. Name John Hamblin
13. Birthplace Fairmont Md.

MOTHER
14. Maiden name ~~Jane~~ Unknown
15. Birthplace ~~Unknown~~ Unknown

16. Informant Mrs. Thomas E. Adkins
Address Salisbury Md. Route 3

17. Burial (Burial, cremation, or removal? Which?) Date thereof April 10 1947 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Md.

18. Funeral director Holloway & Gillis Funeral Home
Address 526 E. Church St. Salisbury Md.

19. 4/10/47 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-4 1947 to 4-8 1947
and that I last saw h.. alive on 4-8 1947

Immediate cause of death	DURATION
Broncho Pneumonia	
Due to Influenza	
Due to	
Other conditions Adeno carcinoma Pancreas Hydrocephalus	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Eliza A. Tunley M. D. or other
Address Salisbury, Md. Date signed 4-8-47

VS. A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01440

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R.D. #1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Francis Adkins

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lama Ann Adkins
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): April 17th 1883
8. AGE: Years: 64 Months: 8 Days: 4 If less than one day: hrs. min.
9. Birthplace: Wango Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Joseph James Adkins
13. Birthplace: Near Delmar Maryland
MOTHER 14. Maiden name: Mary Catherine Holloway
15. Birthplace: R.D. Parsonsburg Maryland
16. Informant: Mrs. Lama A. Adkins
Address: R.D. #1. Pittsville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1947 (month) (day) (year)
Cemetery or crematory: Forest Glen Cem.
Location: Near Parsonsburg Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland
19. 4/23/47 (Date rec'd by registrar) 1947 Margaret C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21st 1947 at 5.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to 19 and that I last saw h[illegible] alive on April 21, 1947 19

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day.
Due to: had had previous cerebral hemorrhages, confined to bed 10 months.	
Due to:	
Other conditions: hypertension, arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Grant L. Lewis M.D. M. D. or other
Address: Salisbury Md. Date signed 4-22-47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Long.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

01441

Reg. Dist. No. 855

1. PLACE OF DEATH
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yr
Hospital, institution, or street address where death occurred: 312 Charles st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 312 Charles st.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ethel Virgie Ardis

3.(b) Social Security Number:

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Walter D. Ardis
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): Aug 8th 1889
8. AGE: Years: 57 Months: 10 Days: 2 If less than one day: hrs. min.
9. Birthplace: Bridgeton Md. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
FATHER 12. Name: John H. Lokey
13. Birthplace: Somerset Co. Md.
MOTHER 14. Maiden name: Sarah E. Mitchell
15. Birthplace: Whaleyville Md.
16. Informant: Mr. Walter D. Ardis
Address: 312 Charles st Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 14 1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Hollings & Walter R. Hollings
Address: Salisbury Md.
19. 4/14, 1947 (Date rec'd by registrar) Harriet B. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10th 1947 at 7.10 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1946, to April 10 1947
and that I last saw h... alive on April 9 1947

	DURATION
Immediate cause of death: duodenitis, internal hemorrhage	3 months
Due to: Carcinoma (adeno) Bile duct	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Common duct obstruction; hepatic metastases. Date of op. June 18, 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William B. Long M.D. M. D. or other
Address: 304 N. Division St. Salisbury, Md. Date signed: April 14, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01442

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Panticoke md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Panticoke md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Sarah E. Barckley

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	A. A.	Married

6.(b) Name of husband or wife: John Barckley
6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): May 11 1900

8. AGE: Years	Months	Days	If less than one day
46	10	22	hrs. min.

9. Birthplace: Panticoke md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Same as above
FATHER 12. Name: Edward Jones
FATHER 13. Birthplace: Panticoke
MOTHER 14. Maiden name: Nellie J. Jones
MOTHER 15. Birthplace: Panticoke md
16. Informant: John Barckley
Address: Panticoke md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 27 1947 (month) (day) (year)
Cemetery or crematory: Pusey Walters
Location: Panticoke Md
18. Funeral director: James H. Stewart
Address: Salisbury md
19. Apr 22 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 April 1947 at 6.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 04 March 1947, to 21 April 1947, and that I last saw her alive on 21 April 1947.

Immediate cause of death	DURATION
Congestive Heart Failure	48 hours
Due to: Hypertensive Arteriosclerotic Heart Disease	3 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard H. Saunders (M.D.) M. D. or other
Address: Nanticoke Md Date signed: 22 April 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

01443 335

Reg. Dist. No. ....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Ticonnico
City or town: Sharptown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Wic
City or town: Sharptown (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William J. Bennett **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Lucy H. Bennett
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): Oct 9 1865

8. AGE: Years: 81 Months: 5 Days: 26 If less than one day: hrs. min.

9. Birthplace: Sharptown Wic Md (Town, county, and state)
10. Usual occupation: Retired Sailor
11. Industry or business:
12. FATHER Name: William J. Bennett
13. Birthplace: Md
14. MOTHER Maiden name: Rachel Robinson
15. Birthplace: Md
16. Informant: Edith Bennett
Address: Sharptown
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4. 7. 1947 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown Md
18. Funeral director: Graham or Bros
Address: Sharptown
19. 4/7 1947 (Date rec'd by registrar) Walter G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1947, at 9-20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946, to April 4 1947
and that I last saw him alive on April 4 19..
Immediate cause of death: Chronic Cardiac Valvular Arterio-Sclerosis — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M.D. M. D. or other
Address: Sharptown Md Date signed: 4/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-6

CERTIFICATE OF DEATH

01444

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: P. G. Hospital, Salisbury Md
How long in hospital or Institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John A. Birckhead

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1906

8. AGE: Years: 40 | Months: 10 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Hebron, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: John A. Birckhead
13. Birthplace: Hebron Md.

MOTHER
14. Maiden name: Lucy Daskiell
15. Birthplace: Nanticoke Md.

16. Informant: John A. Birckhead
Address: Hebron Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)
Cemetery or crematory: Parsonwalkin Cem.
Location: Parsonwalkin Md.

18. Funeral director: David T. Messick
Address: Hebron Md.

19. 4/18/47 (Date rec'd by registrar) 19 47 Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 17, 1947, at 2 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15 1947 to April 17th 1947
and that I last saw him alive on April 17th 1947

Immediate cause of death	DURATION
Septic anemia	
Due to: Staph Septic throat & Strep Pneumonia	Several
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Carried Heare M. D. or other
Address: 303 W. Church St. Salis. Date signed: 4/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

01445

CERTIFICATE OF DEATH

Reg. Diat. No. 327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Jesterville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Jesterville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Roxanna Brooks

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widow

6.(b) Name of husband or wife: James Brooks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 3, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	-	..... hrs. ..... min.

9. Birthplace: Jesterville, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Don't know

FATHER — 13. Birthplace: " "

MOTHER — 14. Maiden name: Amy Jones

MOTHER — 15. Birthplace: Jesterville, Md.

16. Informant: Alan Conway

Address: Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/6/47 (month) (day) (year)

Cemetery or crematory: Colored Cemetery

Location: Jesterville, Md.

18. Funeral director: C. S. Messick

Address: Bivalve, Md.

19. Apr 6 1947 (Date rec'd by registrar) R. Bedford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 19 47, at 4:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 March 19 47 to 3 April 19 47 and that I last saw h alive on 3 April 19

Immediate cause of death	DURATION
Broncho pneumonia type unspecified.	4 day.
Due to Hypertensive Cardio vascular renal disease.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard H. Saunders M.D. M. D. or other

Address: Crisfield Md. Date signed: 6 April 47

MARYLAND STATE DEPARTMENT OF HEALTH

01446

2411 N. Charles St., Baltimore (III-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Somerset Wisonico
City or town: Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, Institution, or street address where death occurred: Penn. Gen. Hosp. Salisbury, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Somerset
City or town: Rural Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Burrels, John

3. (b) Social Security Number: 220-05-4247

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	~~Mar~~ Widowed

6.(b) Name of husband or wife: Lucy Stayford
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years 56 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Mt. Vernon, Md. Somerset (Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER — 12. Name: Nelson Burrels
13. Birthplace: Mt. Vernon, Md.

MOTHER — 14. Maiden name: —
15. Birthplace: —

18. Informant: Harvey Burrels
Address: Mt. Vernon, Md.

19. Burried (Burial, cremation, or removal. Which?) Date thereof April 3, 1947 (month) (day) (year)
Cemetery or crematory: Asbury St Paul's
Location: Mt. Vernon, Md.

18. Funeral director: Dale Disbrell
Address: Princess Anne Md.

19. 4/10, 1947 (Date rec'd by registrar) H. C. Harris & S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/9 1947, at 10:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.. to 19.. and that I last saw him alive on 19..

Immediate cause of death	DURATION
Pulmonary Embolism	sudden death
Due to Thrombosis of Femoral veins & Hemoconcentration	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Salisbury Md. Deputy Med Examiner
M. D. or other
Address: Salisbury Md. Date signed: 4/9/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11447

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Nineteen years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lake St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ethell Carrigan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	Married

6.(b) Name of husband or wife Joseph Carrigan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) about 1893

8. AGE: Years	Months	Days	If less than one day
about 54	—	—	..... hrs. ..... min.

9. Birthplace Chadbourn N.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

FATHER 12. Name George W. Peady

FATHER 13. Birthplace Chadbourn N.C.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Odessa L. Carrigan

Address Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 13 1947 (month) (day) (year)

Cemetery or crematory Hanson

Location Salisbury Md

18. Funeral director Samuel J. Stewart

Address Salisbury Md

19. 4/12 19 47 Carrie L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 47, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 19 47 to April 9 19 47

and that I last saw h[illegible] alive on April 7 19 47

Immediate cause of death Coronary Thrombosis — DURATION 2 Days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. [illegible] M.D.
M. D. or other

Address Salisbury Date signed April 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

01448

Reg. Dist. No. 373

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
Wm. B. Parsons Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: High & Bloom sts.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Armina Dykes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 9. 1877.

8. AGE: Years	Months	Days	If less than one day
69	6	26	hrs. min.

9. Birthplace: Ironshire Md.
(Town, county, and state)
10. Usual occupation: House work at home
11. Industry or business:

FATHER
12. Name: Daniel Lewis
13. Birthplace: Ironshire Md.

MOTHER
14. Maiden name: Charlotte West
15. Birthplace: Near Snow Hill Md.

16. Informant: Mrs. Jack Billbrough
Address: 5402 Delancey St Phila Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 (month) (day) 1947 (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md.

18. Funeral director: Holloway & Co Charles Hall
Address: 520 E Church St Salisbury Md.

19. 4/5, 19 47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3rd 1947 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1947 to April 3rd 1947 and that I last saw h[illegible] alive on April 3rd 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: arteriosclerosis & Hypertension	
Due to: Myocarditis accentuated by a Major Operation	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Procidentia & Cystocele
Contributory:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury: Injured at work?

23. SIGNATURE: Carrie L. Hearn M.D. or other
Address: 130 W Church St Salisbury Md. Date signed: 4/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Sohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

CERTIFICATE OF DEATH

01449

Reg. Dist. No. 239

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother) Sussex
State Delaware County
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. 705E. State St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ellis Mr. Joseph Winder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male MALE	White	Widowed

6.(b) Name of husband or wife Ella Frazier Ellis

6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Dec. 16th 1867

8. AGE: Years	Months	Days	If less than one day
79	3	17	hrs. min.

9. Birthplace Delmar Md.
(Town, county, and state)

10. Usual occupation Retired Railroad Conductor

11. Industry or business Pennsy. Railroad

FATHER 12. Name William. C. Ellis
13. Birthplace Delmar Md.

MOTHER 14. Maiden name Frances Hearn
15. Birthplace Delmar Md.

16. Informant Mrs. Frances. Ellis Hastings
Address 705 E. State St. Delmar Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April. 8 th 1947 (month) (day) (year)
Cemetery or crematory M. P. Delmar Del.
Location Delmar Del.

18. Funeral director Holloway & Co. PER Preston Holloway
Address 520 E. Church St. Salisbury Md.

19. 4/5 (Date received by registrar) 1947 Harriet D. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947, at 4.03 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Uremic coma	3 days
Due to Cancer of prostate gland	2 years
Due to	
Other conditions Metastasis of Ca in liver	2

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. V. Sohler M. D. or other
Address Delmar, Del. Date signed 4-3-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 894

01450

CERTIFICATE OF DEATH

Reg. Dist. No. 993

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 years
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Maryland ~~Wicomico~~
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 Camden Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY CALDWELL FOOKS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice Gunby Fooks
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): October 17, 1876

8. AGE: Years	Months	Days	If less than one day
70	5	29	...hrs. ...min.

9. Birthplace: Salisbury, Wicomico Co., Maryland
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Hardware

FATHER
12. Name: Merrill Fooks
13. Birthplace: Wicomico Co., Maryland

MOTHER
14. Maiden name: Emma Parker
15. Birthplace: Salisbury, Maryland

16. Informant: Alice G. Fooks
Address: Salisbury, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/47 (Month) (day) (year) 3 p.m.

Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Maryland

19. 4/18/47 (Date rec'd by registrar) H. Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 16 1947 at 7:25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14, 1947 to April 16 1947
aed that I last saw h.i.m alive on April 16, 1947:

Immediate cause of death	DURATION
Cerebral Embolus.	2 days
Due to Arteriosclerosis.	(?)
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ...Injured at work?

23. SIGNATURE: D. Pitt Harman M.D.
M. D. or other
Address: 238 Camden Ave. Date signed April 16, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Starr

Mrs Herrick
Johnson C1451

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 52 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Som.

City or town Princess Anne (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Green

3. (b) Social Security Number

4. Sex Femal

5. Color or race White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 9, 1947

8. AGE: Years — Months — Days — If less than one day 1 hrs. ... min.

9. Birthplace P.G.H. Salis., Md. (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Howard M. Green, Jr.

13. Birthplace Som. Co., Md.

MOTHER 14. Maiden name Juanita Abbott

15. Birthplace Som. Co., Md.

16. Informant J. Arthur Howell

Address Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 10, 1947 (month) (day) (year)

Cemetery or crematory Manokin Presbyterian Cem.

Location Princess Anne, Md.

18. Funeral director J. Arthur Howell (acting)

Address Princess Anne, Md.

19. 4/10, 1947 (Date rec'd by registrar) Harriet G. Johnson Registrar (Local)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1947, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1947, to April 9 1947

and that I last saw her alive on April 9 1947

Immediate cause of death Anencephalic monster | DURATION 1 hr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.A. Rademaker M.D. (M. D. or other)

Address Salisbury Md. Date signed 4/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Lewis

01452

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred: RD. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland. County Wicomico
City or town Salisbury Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 3 (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Amelia Anne Hancock
3. (b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Ebenezer L Hancock
6.(c) If alive, give age dead years
7. Birth date of deceased (mo., day, yr.) Sept 7th 1861
8. AGE: Years 85 Months 7 Days 0 If less than one day ... hrs. ... min.
9. Birthplace Near Laurel Del. (Town, county, and state)
10. Usual occupation House work
11. Industry or business at home
FATHER 12. Name unknown
13. Birthplace unknown
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Mr Ernest Hancock
Address Salisbury Md. Route # 3
17. Burial Date thereof April 10. 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Walstons Md
18. Funeral director Holloway & Co Per Thurston Holloway
Address 540 E Church St. Salisbury Md.
19. 4/10, 1947. Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 7th 1947 at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1947 19.. to day of death 19..
and that I last saw her alive on April 5, 1947. 19..
Immediate cause of death Chronic myocarditis (congestive heart failure) — DURATION ?
Due to
Due to
Other conditions Hypertension Senility
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Grant R. Lewis M.D. M. D. or other
Address Fruitland Maryland Date signed 4-8-47.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

01453

Reg. Diat. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Tyaskin md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother)

State: Md County: Wicomico

City or town: Tyaskin R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Annie Hudson

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a-a.	Married

6.(b) Name of husband or wife: William Hudson Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1875

8. AGE:

Years	Months	Days	If less than one day
72			....hrs. ....min.

9. Birthplace: Salisbury md (Town, county, and state)

10. Usual occupation: housekeeping

11. Industry or business: Same as above

FATHER — 12. Name: John Dorman

FATHER — 13. Birthplace: Salisbury md

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Ray Taylor

Address: Tyaskin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 23-1947 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury md

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 4/23 19 47 (Date rec'd by registrar) H. R. Woolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 April 1947 at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 April 1947 to 21 April 1947 and that I last saw her alive on 20 April 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	72 hours
Due to: Hypertensive Arterio -	
Due to: Sclerotic vascular disease	5
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Richard H. Saunders M.D. M. D. or other

Address: Hebron Md Date signed 23 April 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

01454

FILE No. G 11 6 JUN 13 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 1408 N. Division st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1408 N. Division
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sallie V. Hudson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Valley E. Hudson
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Aug. 12-1908

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
38 39	8	13		

9. Birthplace: Laurel Delaware (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:

FATHER
12. Name: George Bacon
13. Birthplace: Laurel Delaware

MOTHER
14. Maiden name: Alice
15. Birthplace: Delaware

16. Informant: Mr. Valley E. Hudson
Address: 1408 N. Division st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 28-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury, Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland.

19. 4/26 1947 Mabel E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25th 1947, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1946 to April 25 1947
and that I last saw h[illegible] alive on April 25 1947

	DURATION
Immediate cause of death: Acute cardiac failure	
Due to: Chronic myocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed: 4-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

LETTER FROM Dr. Sartorius, another from f.d. Stewart. filmed G113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144)

10-28-47 adding mid.initial - I

01455

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico md
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. rfd
(If rural, give LOCATION)
2.(a) If veteran, name war World War No 2

3.(a) FULL NAME Jerome H. Jacobs (JEROME H. JACOBS)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife no
6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) June 25 1927

8. AGE: Years 19 Months 10 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace Berlin md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER 12. Name Leato Jacobs

FATHER 13. Birthplace Gethsemane md.

MOTHER 14. Maiden name Lena Purnell

MOTHER 15. Birthplace Berlin md

16. Informant Robert Jacobs
Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1. 1947 (month) (day) (year)
Cemetery or crematory Pine
Location Berlin md

18. Funeral director Janus H. Stewart
Address Salisbury md

19. 4/29 1947 Registered by Joshua [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 1947, at 11 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gun shot wound in rt temple Suicidal. Cause R	(3)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide (S) Date of April 27 47
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John L. Riley Dep. Med Exam M. D. or other
Address [illegible] Dale signed 4/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 117-a

01487

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire stay four hours
Hospital, Institution, or street address where death occurred: Peninsula Hospital
How long in hospital or institution? 24 hours D.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Ocean City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. /
(If rural, give LOCATION)
2.(a) If veteran, name war World War One

3.(a) FULL NAME Jefferson Wallace

3.(b) Social Security Number no

4. Sex Male
5. Color or race C
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Violet B Jefferson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb 28 1892
8. AGE: Years 54 Months 1 Days 16 If less than one day ..... hrs. ..... min.
9. Birthplace Madison Miss (Town, county, and state)
10. Usual occupation Taylor
11. Industry or business Same as above
FATHER 12. Name Clark Jefferson
13. Birthplace Madison Miss.
MOTHER 14. Maiden name Delvia Watson
15. Birthplace Madison Miss
16. Informant Mrs Violet Jefferson
Address Ocean City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 21-1947 (month) (day) (year)
Cemetery or crematory Lincoln
Location Chicago Illinois
18. Funeral director James H Stewart
Address Salisbury Md
19. 4/16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/15/47 at 11 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-10 1947, to 4/15 1947 and that I last saw h... alive on 4-15 1947

	DURATION
Immediate cause of death: Post operative bleed	24 hrs
Due to: Gastric ulcer	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gastric ulcer
Date of op. 4/14/47
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L O Rademacher M.D.
M. D. or other
Address Salisbury Md Date signed 4/16/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01456

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula Gunical Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Dawson Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22- 1947

8. AGE: Years | Months | Days | If less than one day: hrs. 40 min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Johnson Clarence Purnell
13. Birthplace: Salisbury, maryland.

MOTHER
14. Maiden name: Marshall, Beatrice Virginia
15. Birthplace: Greenbrad Mulle, Virginia

16. Interment
Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Apr. 22, 1947 (month) (day) (year)
Cemetery or cremetory: Peninsula Gunical Hospital
Location: Salisbury, maryland

18. Funeral director
Address

19. 4/26/47 (Date rec'd by registrar) Carrie E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1947, at 1:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947, to April 22 1947, and that I last saw her alive on April 22 1947

Immediate cause of death	DURATION
Congenital hydrocele	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Congenital hydrocele
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William A Gray M.D. M.D. or other
Address: Salisbury, Md. Date signed: 4/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

01457

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Peninsula

Hospital, institution, or street address where death occurred: General Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Johnson, Elijah

3.(b) Social Security Number 221-14-9378

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elsosie Johnson

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): May 3, 1907

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
39	10	9		

9. Birthplace: Salisbury, Wicomico county, Maryland (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business: Saw Mill

FATHER — 12. Name: Archibald Johnson

FATHER — 13. Birthplace: Snow Hill, Md.

MOTHER — 14. Maiden name: Janie Johnson

MOTHER — 15. Birthplace: Snow Hill, Md.

16. Informant: Lillie May Chamberlain

Address: Laurel, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 14, 1947 (month) (day) (year)

Cemetery or crematory: Concord Colored Cem.

Location: Concord Del.

18. Funeral director: J. J. Frantom & Son.

Address: Federalsburg, Md.

19. 4/18/47 (Date received by registrar) Carroll S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/10 1947, at 12 10/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to April 10 1947

and that I last saw alive on April 10 1947

Immediate cause of death	DURATION
Bronchopneumonia	24 hrs.
Due to: Burns Partial Loss Body	week 22
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: Burns of body, Bronchopneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3/22/47

Where did injury occur? Laurel (City or town) Sussex (County) Del (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Went into burning house Injured at work? No

23. SIGNATURE: L. A. Rademaker M.D. M. D. or other

Address: Salisbury, Md. Date signed: 4/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of date of death and date of accident is shown on G 112 10/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01458

Reg. Dist. No. 333

M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Sharptown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Laurel Del R F D No 3

(If rural, give LOCATION)

2.(a) If veteran, name war World War No 2

3.(a) FULL NAME Johnson Williams

3.(b) Social Security Number Could not be located

4. Sex Male

5. Color or race C

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Imogene Johnson

Yes 6.(c) If alive, give age Don't know years

7. Birth date of deceased (mo., day, yr.) Aug 9 1916

8. AGE: Years 30 about Months 7 Days 27 If less than one day ... hrs. ... min.

9. Birthplace Mardella Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Marvel Packing Co

FATHER 12. Name Isaac Johnson

13. Birthplace Mardella Md

MOTHER 14. Maiden name Pauline Dixon

15. Birthplace Mardella Md

16. Informant Imogene Johnson

Address Laurel Del R F D No 3

17. Burial Date thereof Apr 8 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleas...

Location Near Sharptown Md

18. Funeral director James H. Stewart

Address Salisbury Md

19. 4/8 1947 Harriet ... Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/4 5 1947 at 2:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Medical examiner's inquest

Immediate cause of death Burns of entire body — DURATION 1 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4/4 (3) /47

Where did injury occur? Sharptown Wicomico Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Mill

Means of injury Fell in vat of boiling water Injured at work? yes

23. SIGNATURE Jas. ... Deputy Med Exam. M. D. or other

Address Salisbury Md Date signed 4/... /47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-D)

CERTIFICATE OF DEATH

01459

Reg. Dist. No. 3-93

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address (where death occurred): Peninsula General Hospital
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somerset Co.
City or town: Dames Quarter
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: Samuel C. Jones

3. (b) Social Security Number: 219-05-3179

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A.A.	Married

6.(b) Name of husband or wife: Henerietta Jones
6.(c) If alive, give age: Yes Don't know years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years 64 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Dames Quarter md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Benjamin Jones
13. Birthplace: Dames Quarter

MOTHER
14. Maiden name: Mary Gale
15. Birthplace: Dames Quarter md

16. Informant: Mrs. Henerietta Jones
Address: Dames Quarter md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 22, 1947 (month) (day) (year)
Cemetery or crematory: Dames Quarter
Location: Dames Quarter md

18. Funeral director: James F. Duvall
Address: Salisbury, Md

19. 4/23, 19 47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8 19 1947 at 2 15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1947, to April 8, 1947
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Uremia	7 days
Due to: Hypertrophied Prostate & Urethral Stricture	1 month 1 month
Due to:	
Other conditions: Urinary Extravasation	7 days

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophied prostate Urinary Extravasation Date of op. 4/10/47
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ja Rademaker MD M. D. or other
Address: Salisbury Md Date signed 4/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

01460

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ruby ann Lambertson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Walter Lambertson
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): April 17, 1897

8. AGE:

Years	Months	Days	If less than one day
49	11	24	...hrs. ...min.

9. Birthplace: Pocomoke, Worcester, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Harm Dutton
13. Birthplace: Md.

MOTHER
14. Maiden name: Emma Tilghman
15. Birthplace: Md.

16. Informant: Walter Lambertson
Address: Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13, 1947 (month) (day) (year)
Cemetery or crematory: Wells Hill Baptist Cemetery
Location: Pocomoke

18. Funeral director: Henry H. Watson
Address: Pocomoke City, Md.

19. 4/10, 1947 (Date rec'd by registrar) Bessie L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/11, 1947, at 3 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to 4/11, 1947
and that I last saw her alive on 4/11, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unk
Due to Pneumonia	Unk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op. 3/31/47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: W. H. Watson, M. D., or other
Address: ... Date signed: 4/11/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1526

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:
County: Oscomico
City or town: Pen. Gen. Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: ( ) County: Som
City or town: Oriole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: Baby Lawrence

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1947

8. AGE:

Years	Months	Days	If less than one day
			under 1 day hrs. min.

9. Birthplace: Pen. Gen. Hospital (Town, county, and state)
10. Usual occupation: none
11. Industry or business:
FATHER 12. Name: Preston Lawrence
13. Birthplace: Oriole Md.
MOTHER 14. Maiden name: Marion Powell
15. Birthplace: Princess Anne Md.
16. Informant: Preston Lawrence
Address: Oriole Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2 1947 (month) (day) (year)
Cemetery or crematory: Jr. Order of Mechanics
Location: Oriole Md.
18. Funeral director: Dale Dashiell
Address: Princess Anne
19. 4/2/47 (Date rec'd by registrar) 19 47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-1-47 19 ..., at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-31 19 47, to 4-1 19 47
and that I last saw him alive on 4-1-47 19
Immediate cause of death — DURATION
Due to: Prematurity
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda A. Fowler M. D. or other
Address: Salisbury Md. Date signed 4-1-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

01461

Reg. Dist. No. 933

Home

M

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1111 E. Church street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Littleton Mrs. Rose

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Irving A. Littleton
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) July 28- 1861

8. AGE: Years 85 | Months 8 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace near Powellville Md.
(Town, county, and state)

10. Usual occupation
11. Industry or business at Home

FATHER
12. Name Riley Shockley
13. Birthplace Wic. Co. Md

MOTHER
14. Maiden name Hedrietta Ellis
15. Birthplace near Powellville Md.

16. Informant Mrs. Virgie Powell
Address 1111 E. Church st. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 27- 1947 (month) (day) (year)
Cemetery or crematory Old St. Johns Cem.
Location Powellville Maryland

18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Maryland.

19. 4/26 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24- 1947, at 4 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/19 1947 to 4/24 1947 and that I last saw her alive on 4/24/47 1947

Immediate cause of death — DURATION

Myocarditis; Chronic, ---- 5 years.

Due to

Due to Arterio-sclerosis, with hypertension.

Other conditions Colitis.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. L. Jeanes M.D.
M. D. or other
Address Salisbury Md. Date signed 4/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Gilmore

01462

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred: 313, Poplar Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313, Poplar Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sarah Anne Lively

3. (b) Social Security Number

4. Sex Female
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Andrew J. Lively
6. (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) May 14 - 1877
8. AGE: Years 69 Months 11 Days 1 If less than one day ... hrs. ... min.
9. Birthplace Racine W. Va.
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name James Midkiff
13. Birthplace Boone Co. W. Va.
MOTHER 14. Maiden name Martha Jane James
15. Birthplace Roanoke Va.
16. Informant Mr. Andrew J. Lively
Address 313, Poplar St. Salisbury Md.
17. Burial Date thereof April 18 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Wicomico Mem. Park
Location Salisbury Maryland
18. Funeral director Holloway & Co Walter R. Holloway
Address Salisbury Maryland
19. 4/17 1947 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1947 at 8:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 1946, to April 15 1947
and that I last saw her alive on April 15 1947

	DURATION
Immediate cause of death Arteriosclerotic Heart Disease	Symptoms 2 yrs.
Due to Coronary artery sclerosis	
Due to	
Other conditions Diabetes Mellitus	5 yrs
Hypertension	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. David J. Gilmore M.D.
M. D. or other
Address 301 N. Division St. Salisbury Date signed April 17 1947

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01463

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 min in River
Hospital, institution, or street address where death occurred: Peninsula General Hosp (Possibly Dead on arr, apparently)
How long in hospital or institution? 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 Wicomico St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Donald Forrest Lord

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 8 years (May 7-1938)
8. AGE: Years: 8 | Months | Days | If less than one day: hrs. min.
9. Birthplace: Falls River Mass. (Town, county, and state)
10. Usual occupation: School boy.
11. Industry or business

FATHER
12. Name: Elmer F. Lord
13. Birthplace: Falls River, Mass.

MOTHER
14. Maiden name: Dorothy Murray
15. Birthplace: Taunton Mass.

18. Informant: Mr. Elmer Forest Lord
Address: 305 Wicomico St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 19-1947 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury, Maryland.

18. Funeral director: Walter R. Holloway & Holloway
Address: Salisbury Maryland.

19. 4/17/1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1947, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1947, to April 16 1947, and that I last saw h[illegible] alive on April 16 1947

	DURATION
Immediate cause of death: Respiratory failure	
Due to: Drowning	45 min.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 16-April 1947
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Wicomico River
Nature of injury: Drowned. Injured at work? No

23. SIGNATURE: Robert R. Starr M.D.
Address: Salisbury Date signed 4-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Imley.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01464

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: 624 W. Main st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 624 W. Main st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: David Josiah Malone
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Josephine Malone
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): Oct. 5-1869

8. AGE: Years: 77 Months: 6 Days: 14 If less than one day: hrs. min.
9. Birthplace: Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Railroad Man
FATHER 12. Name: Wesley Malone
13. Birthplace: Wicomico Co. Md
MOTHER 14. Maiden name: Aikman
15. Birthplace: Wicomico Co. Md
16. Informant: Mrs Josephine Malone
Address: 624 W. Main st. Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof April 21-47 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Maryland
18. Funeral director: Hellen & Walter R Hellen
Address: Salisbury Maryland
19. 4/21, 19 47 (Date rec'd by registrar) Rachael L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19-47, at 5-30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1947, to April 19 1947
and that I last saw h.i.m. alive on April 5 1947
Immediate cause of death: Uremia — DURATION
Due to: Chronic nephritis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Thomas A Smiley M. D. or other
Address: Salisbury Md Date signed 4-19-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

01465

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 3 hrs 44 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Bethel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Laura E. Massey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William H. Massey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/11/1875

8. AGE: Years 71 | Months 10 | Days 3 | If less than one day: hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William D. Knowles
13. Birthplace: Delaware

MOTHER
14. Maiden name: Louise Wallace
15. Birthplace: Delaware

16. Informant: William H. Massey
Address: Bethel, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/47 (month) (day) (year)
Cemetery or crematory: Bethel Cem.
Location: Bethel, Del.

18. Funeral director: Harry E. Williams
Address: Fredericksburg, Md.

19. 4/14/47 (Date received by registrar) 1947 H. Harriet Bell Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 14 1947 at 5:54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1947, to April 14 1947
and that I last saw h.. alive on April 14 1947

	Duration
Immediate cause of death: Arteriosclerotic Heart disease	1 yr.
Due to: with Heart failure	
Due to:	
Other conditions: Hypertension Cerebral Thrombosis	Symptoms 1 year 12 hours

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David J. Gehrmann M.D.
M. D. or other
Address: 301 N. Division Salisbury Md. Date signed: April 14, 1947

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

01466

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 17 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: White Haven

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD. 3 Parkin P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME (Messick) Mr. George Holland Messick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie M. Messick

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Jan. 27-1875

8. AGE: Years: 72 Months: 2 Days: 18 If less than one day: hrs. min.

9. Birthplace: Nanticoke Md. (Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business

FATHER — 12. Name: John Messick

FATHER — 13. Birthplace: Nanticoke Md

MOTHER — 14. Maiden name: Annie R. Maley

MOTHER — 15. Birthplace: Nanticoke Md.

16. Informant: Mary J. Messick

Address: White Haven Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: April 17-47 (month) (day) (year)

Cemetery or crematory: Wicomico Mem. Park

Location: Salisbury Maryland

18. Funeral director: Hollowa & Co. Walter R. Fillow

Address: Salisbury Maryland

19. 4/17/47 (Date rec'd by registrar) Edward E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1947 at 5 P. M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1947 to April 15 1947

and that I last saw him alive on April 15 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: Sp. time

Due to: — Duration:

Due to: — Duration: Sp. time

Other conditions: Epithelioma right upper lip. Benign Prostatic Hypertrophy (Include pregnancy within 3 months of death) 6 months

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Injured at work?

Nature of injury

23. SIGNATURE: David J. Gilmore M. D.

M. D. or other

Address: 3 N. Division Salisbury Md. Date signed: April 15, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01467

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County:
City or town: Blades
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 North Market
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ISABEL BEAUCHAMP MORGAN

3.(b) Social Security Number: 218-16-6015

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank LeRoy Morgan
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): September 12, 1924

8. AGE: Years	Months	Days	If less than one day
22	7	1	hrs. min.

9. Birthplace: Salisbury, Wicomico Co., Maryland
(Town, county, and state)
10. Usual occupation: Office Secretary
11. Industry or business: Medical Doctor
FATHER 12. Name: Barney A. Beauchamp
13. Birthplace: Marion. Somerset Co.
MOTHER 14. Maiden name: Lillian Laws
15. Birthplace: Salisbury, Wicomico Co.
16. Informant: Barney A. Beauchamp
Address: 104 Winder St., Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/16/47 (month) (day) (year) 2:30
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Maryland
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.
19. (Date rec'd by registrar) 4/18/47 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13, 1947, at 9:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1947, to April 13, 1947
and that I last saw h.e.r alive on April 13 1947
Immediate cause of death: Bronchopneumonia — DURATION
Due to:
Due to:
Other conditions: Hypoglycemia
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results: Bronchopneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Phyllis A. Lusby M.D., or other
Address: Salisbury, Md. Date signed 4-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01468

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164)

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: W. Isabella street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-born infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: W. Isabella (If rural, give LOCATION)
2.(a) If veteran, name war: World War, I

3.(a) FULL NAME: Charles A. Murphy
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lena Murphy
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 19-1890
8. AGE: Years: 56 Months: 5 Days: 6 If less than one day: hrs. min.
9. Birthplace: Minerva N.Y. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: Joseph Murphy
13. Birthplace: New York N.Y.
MOTHER 14. Maiden name: Roxana Bunnell
15. Birthplace: Near Minerva N.Y.
16. Informant: Mrs. Lena Murphy
Address: 110. Clay st. Salisbury Md.
17. Burial, cremation, or removal: Burial Date thereof: Apr. 29 47 (month) (day) (year)
Cemetery or crematory: Catholic Cem.
Location: Olivette ville N.Y.
18. Funeral director: Holloway & C. Walter R. Holloway
Address: Salisbury Maryland
19. 4/26/47 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1947, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate
and that I last saw him alive on 4/25 1947
Immediate cause of death: Hemorrhage — DURATION
Due to: Knife wound of stomach
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 4/25/47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home.
Specify injury: Injured at work? no
23. SIGNATURE: Chas. E. Fisher M.D.
Hospital, Medical Examiner M. D. or other
Address: Salisbury Md. Date signed: 4/25/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 323

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, Institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Allen ✓
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Annie Hallie Nichols

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female ✓	White	Married

6.(b) Name of husband or wife: Elias N. Nichols
6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): May 27, 1865.

8. AGE: Years	Months	Days	If less than one day
81	10	27	...hrs. ...min.

9. Birthplace: Wicomico Co. Md. (Town, county, and state)
10. Usual occupation: At Home ✓
11. Industry or business:

FATHER
12. Name: Anthony Pollitt
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Hillian N. Toadvine
15. Birthplace: nr Allen, Md.

16. Informant: Hillian N. Hallie
Address: Fruitland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/26/47 (month) (day) (year)
Cemetery or crematory: Methodist Church
Location: Allen, Md.

18. Funeral director: De Hill & Johnson Co.
Address: Salisbury, Md.

19. 4/28, 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 24, 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1946 to April 24 1947
and that I last saw h... alive on April 23 1947

Immediate cause of death	DURATION
Pneumonia	4 days
Due to: Chr. Myocarditis	Several Yrs.
Due to: Generalized Arteriosclerosis	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Ellen B. Wheatley M. D. or other
Address: Pr. Anne, Md. Date signed 4/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Frankford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Goldsborough Parsons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	white	infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 27-47

8. AGE: Years | Months: 1 | Days: 29 | If less than one day: hrs. min.

8. Birthplace: Salisbury, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: William G. Parsons
13. Birthplace: Delaware

MOTHER
14. Maiden name: Helena Ellingsworth
15. Birthplace: Delaware

16. Informant: Mrs. Helena Parsons
Address: Frankford, Delaware #2

17. Burial (Burial, cremation, or removal—Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Bethesda Cemetery
Location: Bethesda, Delaware

18. Funeral director: Henry Waters
Address: Pocomoke, Md.

19. 4/8, 1947. Harriet E. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 6, 1947, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 1947, to ..., 1947, and that I last saw h... alive on ..., 1947.

Immediate cause of death	DURATION
Bronchopneumonia, all lobes	12 hours
Due to: acute toxic degeneration Spleen + kidneys	
Due to: acute generalized toxic	
Other conditions: Infected bedsore	

(Include pregnancy within 3 months of death)

Major findings of operation: as above. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 4/7/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Lowry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

0147i

Reg. Dist. No. 033

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Delaware County: Sussex
City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Dunton (Twin 2.)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 19-1947

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland. (Town, County, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Dunton George Gordon
13. Birthplace: Sharptown, Maryland.

MOTHER 14. Maiden name: Brown Mary Patricia
15. Birthplace: Bridgeville, Delaware

16. Informant
Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Apr 20 1947 (month) (day) (year)
Cemetery or crematory: Peninsula General Hospital
Location: Salisbury, Maryland

18. Funeral director
Address

19. 4/26, 1947 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19- 1947, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-17-47, 19, to 4-19-47, 19; and that I last saw h. alive on 4-19-47, 19

Immediate cause of death	DURATION
Prematurity (Imm)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee F. Lowry M.D. (M. D. or other)
Address: Fruitland Date signed: 4-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Mayer-Lowry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01472

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Delaware County Sussex
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Quinton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 17- 1947

8. AGE: Years | Months | Days | If less than one day ..... hrs. 3 min.

9. Birthplace Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name George Garden Quinton
13. Birthplace Shaptown Maryland

MOTHER 14. Maiden name Bruton Mary Beatrice
15. Birthplace Laurel Delaware

16. Informant Hospital
Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Apr. 18, 1947 (month) (day) (year)
Cemetery or crematory Cremation
Location Peninsula General Hospital

18. Funeral director Peninsula General Hospital
Address Salisbury Maryland

19. 4/21/47 (Date rec'd by registrar) 19 47 Gabriel L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-17-47 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to 4-17- 19 47 and that I last saw h[illegible] alive on 4-17- 19 47

Immediate cause of death Prematurity

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Lee L. Lowry M.D.
M.D. or other
Address Fruitland Date signed 4-18-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

01473

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Diat. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Fyaskin, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Fyaskin
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hilliary James Robertson

3.(b) Social Security Number 212-14-4459 8

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	col.	married

6.(b) Name of husband or wife Carrie V. Robertson

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) May 12, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	-	hrs. min.

9. Birthplace Fyaskin, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name unknown

15. Birthplace "

16. Informant Mary L. Dashiell

Address Fyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/15/47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Parsons Cemetery - Fyaskin

18. Funeral director C. A. G. Messick

Address Bivalve, Md.

19. Apl 15 1947 (Date rec'd by registrar) P. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947, at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946 to April 12 1947 and that I last saw him alive on April 10 1947

Immediate cause of death	DURATION
Acute Myocarditis	2 hours
Due to Cerebral Haemorrhage	
Due to Hypertension	3 Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elmer G. Mavesman M. D. or other

Address Princess Anne, Md. Date signed 4.13.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01474

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Rural 3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 Years

Hospital, institution, or street address where death occurred:

R.D. 3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury Rural 3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Adelaide Schelshorn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Karl Schelshorn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April, 25, 1861

8. AGE: Years	Months	Days	If less than one day
85 85	II	8	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: Martin Adam
13. Birthplace: Germany

MOTHER
14. Maiden name: Mrs. Myer
15. Birthplace: Germany

16. Informant: Mr. John Schelshorn

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/7/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 4/9/47 (Date rec'd by registrar) Harriet B. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3, 1947 at 8.20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1947, to April 3, 1947, and that I last saw h.s.w. alive on April 3, 1947.

Immediate cause of death	DURATION
Bronchitis acute	4 days
Due to Acute Lobar Pneumonia Right	
Due to	
Other conditions Arteriosclerosis Cardiac Enlargement.	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Ucaman M.D.
M. D. or other

Address 230 Camden Ave Salisbury, Md. Date signed April 3, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Insley.

01475

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 225 E. Isabella
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha Dusharoon Shockley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William G. Shockley
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Nov. 17. 1857

8. AGE: Years 89 | Months 4 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Near Allen Md.
(Town, county, and state)

10. Usual occupation Housework
11. Industry or business at home

FATHER
12. Name Samuel Dusharoon
13. Birthplace Near Allen Md.

MOTHER
14. Maiden name Mary Esham
15. Birthplace Near Allen Md.

16. Informant Mrs. Palmer W. Shockley
Address 200 E. Pinehurst ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 9 1947 (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Md.

18. Funeral director Holloway & Co. per Hester Holloway
Address 520 E Church st Salisbury Md.

19. 4/9 1947 Harriet B. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6th 1947 at 6:25 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4-4 1947, to 4-6 1947
and that I last saw h.e.y alive on 4-5-47 1947

Immediate cause of death Bronchio-pneumonia — DURATION
Due to Influenza
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Phyllis A. Insley M. D. or other
Address Salisbury, Md. Date signed 4-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 11

01476

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Jennie L. Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: P. Sidney Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 12 - 1864

8. AGE:

Years	Months	Days	If less than one day
82	7	10	..... hrs. ..... min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Sarah J. Silverman

15. Birthplace: Maryland

16. Informant: Mrs Elizabeth J. Stubbs

Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 26 47 (month) (day) (year)

Cemetery or crematory: Presbyterian

Location: Snow Hill, Md

18. Funeral director: Elmer E. Dennis

Address: Snow Hill, Md

19. 4/26/47 (Date rec'd by registrar) 1947 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 19 47 at 7 45 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 4/22/47 19.. to 4/22/47 19..

and that I last saw h.. alive on 4/22/47 19..

Immediate cause of death	DURATION
Mesenteric Thrombosis	1 day
Due to: Hypertensive Arteriosclerosis	yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Paul Cohen M.D.
M. D. or other

Address: Snow Hill Date signed 4/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Starr

01477

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 802 E. Church st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 802 E. Church St. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Catherine Smith

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Clayton Smith
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Jan. 12-1855
8. AGE: Years 92 Months 3 Days 1 If less than one day ... hrs. ... min.
9. Birthplace Near Pittsville Md. (Town, county, and state)
10. Usual occupation Home work
11. Industry or business at Home
FATHER 12. Name Wesley James Downing
13. Birthplace R.D. Pittsville Md.
MOTHER 14. Maiden name Sarah Catherine Smith
15. Birthplace Worcester Co. Md
16. Informant Mr. Virgil J. Downing
Address Parsonsburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15-1947 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 4/16, 1947. Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1947, at 3:45 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-13 1947, to 4-13 1947
and that I last saw her alive on 4-13 1947

	DURATION
Immediate cause of death Respiratory Failure	
Due to Senility	5 yrs
Due to Arteriosclerosis	15 yrs

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Robert R. Starr M. D.
Address Salisbury Date signed 4-14-47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

01478

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about seven months

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Delaware ave

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Ethell Mary Spriddle

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a.a.	Widow

6.(b) Name of husband or wife: John Spriddle Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1893.

8. AGE: Years	Months	Days	If less than one day
about 54			hrs. min.

9. Birthplace: Quantico Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER — 12. Name: George Price

FATHER — 13. Birthplace: Quantico Md

MOTHER — 14. Maiden name: Annie J. Gadley

MOTHER — 15. Birthplace: Quantico Md

16. Informant: Wm Spriddle

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13 1947 (month) (day) (year)

Cemetery or crematory: Quantico

Location: Quantico Md

18. Funeral director: James A. Stewart

Address: Salisbury Md

19. (Date rec'd by registrar) 4/12 1947 Harriet L. Dixon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1947 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2, 1947, to April 5, 1947 and that I last saw h[illegible] alive on April 2 1947

Immediate cause of death	DURATION
Diabetic Coma	3 day
Due to: Diabetes	Unk.
Other conditions: not known	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. H. Kemble M.D. M. D. or other

Address: Salisbury Md Date signed: 4/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01479

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred 708 Hill Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 708 Hill Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Taylor

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Laura Taylor
6. (c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): March 9th 1893
8. AGE: Years 54 Months 1 Days 4 If less than one day ... hrs. ... min.
9. Birthplace: Green Hill Md.
(Town, county, and state)
10. Usual occupation: Water meter Lyme Line
11. Industry or business
FATHER 12. Name: Charles H. Taylor
FATHER 13. Birthplace: Wicomico Co. Md
MOTHER 14. Maiden name: Lillie Reen
MOTHER 15. Birthplace: P.G. Office Md.
16. Informant: Mrs. Laura Taylor
Address 708 Hill St. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof April 16 1947 (month) (day) (year)
Cemetery or crematory Fruitland Cem.
Location Fruitland Md.
18. Funeral director: Holloway & Walter R. Holloway
Address Salisbury Md.
19. 4/16/1947 (Date rec'd by registrar) Harriet J. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13th 1947 at 130a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1947, to April 13, 1947
and that I last saw him alive on April 13, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 years
Due to —	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Injured at work?

23. SIGNATURE John H. Yeaman M.D. M. D. or other
Address 238 Camden Ave Salisbury Md. Date signed April 15, 1947.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

01480

CERTIFICATE OF DEATH

Reg. Dist. No. 739

1. PLACE OF DEATH:
County: Wicomico
City or town: Shadpoint
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Shadpoint
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mathilda Ernestina Thirsbach (Thierbach)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Frederick Thierbach
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1852

8. AGE:

Years	Months	Days	If less than one day
95	2	4	— hrs. — min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: — At Home

11. Industry or business: —

FATHER
12. Name: Not Known
13. Birthplace

MOTHER
14. Maiden name: Not Known
15. Birthplace

16. Informant: Frederick Gustave Anger
Address: Shadpoint, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/21/47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Shadpoint

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. 4/21/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 47 at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb.-47 19 to 4-18-47 19
and that I last saw her alive on 4-18-47 19

Immediate cause of death	DURATION
Cerebral Hemorr.	
Due to Hypertension	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee L. Lowry, M.D. M. D. or other
Address: Fruitland, Md. Date signed 4-18-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr Rademacher.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-a

01481

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Elizabeth
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Truitt Mrs. Mary

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Truitt Mr. William C.

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 13 - 1884

8. AGE: Years 62 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Delmar Del.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Geo Hastings
13. Birthplace Delmar Del.

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mr. C. Truitt

Address Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 - 8 - 47 (month) (day) (year)

Cemetery or crematory Mt Olive Methodist

Location Delmar Del

18. Funeral director W. S. Bradley

Address Delmar Del.

19. 4/8 1947 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1947 at 9 15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1947, to April 4 1947

and that I last saw h. alive on April 4 1947

	DURATION
Immediate cause of death Pulmonary Embolism	sudden
Due to operation for Carcinoma of Cervix	4 mos
Due to	
Other conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of cervix Uteri Date of op. 3/22/47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Rademacher M.D.
M. D. or other

Address Salisbury Md Date signed 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01482

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worchester
City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Tunnell Williams

3.(b) Social Security Number: 221-16-5039

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1926

8. AGE: Years	Months	Days	If less than one day
21	6	4	hrs. min.

9. Birthplace: Worchester Pittsville Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER — 12. Name: Clayton Tunnell
13. Birthplace: Showell Md
MOTHER — 14. Maiden name: Ellen Purnell
15. Birthplace: Berlin Md
16. Informant: Clayton Tunnell
Address: Pittsville Md

17. (Burial, cremation, or removal. Which?): ✓ Date thereof: 4 (month) 4 (day) 1947 (year)
Cemetery or crematory: Showell Cem
Location: Near Showell Md
18. Funeral director: Henry H. Watson
Address: Powellville Md City

19. (Date rec'd by registrar): 4/3, 1947 — Harriet E. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 – 1947, at 11 30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1947 to April 2 1947
and that I last saw him alive on April 2 1947

Immediate cause of death: Acute Bronchopneumonia — Symptoms 24 hrs.
Due to: Septicemia - type undetermined — Symptoms 48 hours
Due to:
Other conditions: Acute pharyngitis + bronchitis + tracheitis — one week
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of
Autopsy results: See above. Multiple hemorrhages Chronic pyelitis Chronic pyelonephritis of kidneys.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: David J. Gilmore M.D (M. D. or other)
Address: 301 N. Division Date Signed: April 2 1947
Salisbury

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01483

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Bivalve
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 months
Hospital, institution, or street address where death occurred: 13 months
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Maryland County: Wicomico
City or town: Bivalve md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Martin Tuttle Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Louise Tuttle
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Feb. 23. 1893

8. AGE: Years	Months	Days	If less than one day
54	1	19	hrs. min.

9. Birthplace: Budapest Hungary (town, county, and state) Retired
10. Usual occupation: Detective New York City
11. Industry or business: Police Dept Retired

FATHER
12. Name: Martin Tuttle
13. Birthplace: Budapest Hungary

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. Louise Tuttle
Address: Bivalve Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1947 (month) (day) (year)
Cemetery or crematory: Queens Long Island
Location: New York N.Y.

18. Funeral director: Glenn Merrick
Address: Bivalve Maryland.

19. Apr. 12 1947 (Date rec'd by registrar) R. Bedford Tuttle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12th 1947 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 April 1947 to 12 April 1947 and that I last saw him alive on 11 April 1947.

	DURATION
Immediate cause of death: Coronary Occlusion.	3 days.
Due to: Arterio-sclerotic Heart Disease.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward A. Saunders M.D.
M. D. or other
Address: Pocomoke Md. Date signed 13 April 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55)

CERTIFICATE OF DEATH

01484

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 years
Hospital, institution, or street address where death occurred: 717 E. Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 717 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sadie Ulman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1875.

8. AGE: Years: 71 | Months: 4 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Salisbury, Wicomico, Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER
12. Name: Isaac Ulman
13. Birthplace: Ohio

MOTHER
14. Maiden name: Velora Long
15. Birthplace: Penn.

16. Informant: Mr. Bernard Ulman
Address: 363 Springdale Ave., Balto. 16, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 4/22/47 (month) (day) (year)
Cemetery or crematory: Oak Shaden
Location: Baltimore, Md.

18. Funeral director: E. Wells Johnson Co.
Address: Salisbury, Md.

19. 4/21/47 (Date rec'd by Registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 20, 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to 4/20 1947
and that I last saw h... alive on 4/19 1947

Immediate cause of death	DURATION
Sarcoma of Lungs	1 yr.
Due to: Metastasis from sarcoma of left knee joint	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Chas. T. Truitt, 2nd M. D. or other
Address: Salisbury, Md. Date signed: 4-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Cramer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (81-a)

CERTIFICATE OF DEATH

01485

Reg. Dist. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH: County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred: 113 Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 304 Barclay st. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emma V. Walker

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Martin Guy Walker

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug 1st 1898

8. AGE: Years: 48 Months: 8 Days: 10 If less than one day: hrs. min.

9. Birthplace: Fairmont Md. (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business: at Home

FATHER 12. Name: Winfield Scott Shelton

FATHER 13. Birthplace: Westmoreland Co. Va.

MOTHER 14. Maiden name: Jeanette Cox

MOTHER 15. Birthplace: Fairmont Md.

16. Informant: Mrs. Jeanette Wells

Address: 304 Barclay st. Salisbury

17. Burial, cremation, or removal. Which?: Burial Date thereof: April 14-1947 (month) (day) (year)

Cemetery or crematory: Parsons Cem

Location: Salisbury Md

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Md.

19. (Date rec'd by registrar) 4/14/47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11th 1947 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1947, to April 11 1947 and that I last saw h[illegible] alive on April 11 1947

Immediate cause of death	DURATION
Meningitis, pneumococcic	36 hours
Due to: Spinal fluid culture, negative. CWSR	
Due to:	
Other conditions: Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. R. Cramer M.D. M. D. or other

Address: Salisbury, Md. Date signed: 4/14/47

01486

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 11 334

1. PLACE OF DEATH:

County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred: 108 Spruce St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Spruce (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Mitchell Walker

3.(b) Social Security Number 717-07-9009

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Dena R. Walker

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov 23 - 1875

8. AGE: Years 71 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Harrisburg, Pa. (Town, county, and state)

10. Usual occupation Retired Conductor

11. Industry or business Penn. Railroad Co

FATHER 12. Name Maryland Walker

FATHER 13. Birthplace Penn.

MOTHER 14. Maiden name Nancy Barnett

MOTHER 15. Birthplace Penn.

16. Informant Mrs. Joseph M. Walker

Address Delmar Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-9-47 (month) (day) (year)

Cemetery or crematory Mt. Olive Methodist

Location Delmar Del.

18. Funeral director W. S. Isaacs Co

Address Delmar Del

19. April 9, 1947 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1947 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 1947 to April 6 1947

and that I last saw h... alive on April 6 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 days
due to Hypertension Cardio Vascular disease	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Bynum M. D. or other

Address Delmar Del Date signed 4/7/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

01488

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 43 years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 805 Delaware St
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Annie Waters

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Married

6.(b) Name of husband or wife: John Waters
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1886

8. AGE: Years	Months	Days	If less than one day
about 61			..... hrs. ..... min.

9. Birthplace: Mecklenburg Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Same as above
FATHER 12. Name: Unknown
13. Birthplace: unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: unknown
16. Informant: Ola Jones
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 13 1947 (month) (day) (year)
Cemetery or crematory: Hanalon
Location: Salisbury Md
18. Funeral director: Jankard P. Stewart
Address: Salisbury Md
19. 4/12, 1947 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 8, 1947 at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1947, to April 8, 1947
and that I last saw her alive on April 8, 1947

Immediate cause of death	DURATION
Uremia	2 days
Due to: Acute Nephritis	1 month
Due to: Hypertension	?
Other conditions: Myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: G. A. Lemmon M.D.
M. D. or other
Address: Salisbury Md Date signed: 4/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-M)

CERTIFICATE OF DEATH

0148

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hrs 50 min
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: White, Baby Boy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April 21st 1947

8. AGE: Years | Months | Days | If less than one day: 7 hrs. 50 min.

9. Birthplace: Salisbury Wicomico Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER
12. Name: Mrs. Charles Edward White
13. Birthplace: Berlin Maryland.
14. Maiden name: Betty Jean Evans
15. Birthplace: Willards Md.

16. Informant: Mr. Charles E. White
Address: Willards Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 23-1947 (month) (day) (year)
Cemetery or crematory: Pines Cem.
Location: Willards Maryland.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.

19. 4/23/47 (Date rec'd by registrar) 19 H. C. Harris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21st 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1947 to April 21 1947 and that I last saw him alive on April 21 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to: Umbilical hernia (anomaly at birth)	5 hrs
Due to: attempted reduction by operation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: All of liver, pancreas, spleen, intestines were in scrotal sac
Date of op. 4-21-47
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Robert R. Starr M. D. or other
Address: Salisbury Date signed 4-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-Q)

CERTIFICATE OF DEATH

01490

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Wicomico

County

City or town Parsonsburg.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

RD #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Ella White

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 13-1872

8. AGE: Years 74 | Months 8 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace RD #2 Parsonsburg Md

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name E. George White

13. Birthplace RD. Parsonsburg Md

MOTHER 14. Maiden name Maria E. Mills

15. Birthplace RD #3 Salisbury Md.

16. Informant Mr. Walter R. White

Address RD #2 Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15-47 (month) (day) (year)

Cemetery or crematory Mon Cem.

Location RD. #2 Parsonsburg Md

18. Funeral director Holloway & Walter R. Holloway

Address Salisbury Md.

19. 4/16, 1947. Harriet E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to April 12 1947

and that I last saw her alive on April 1 1947

Immediate cause of death	DURATION
Arteriosclerotic C-V-R disease	
Due to Multiple Strokes	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William D. Gray M.D. M. D. or other

Address Salisbury, Md Date signed 4/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

01491

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Willards
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John A Wilkins

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Margaret E Wilkins
6.(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): May 28 1892
8. AGE: Years: 55 Months: Days: If less than one day: hrs. min.
9. Birthplace: Willards Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: John Fountain Wilkins
13. Birthplace: Md
MOTHER 14. Maiden name: Lona Hall
15. Birthplace: Md
16. Informant: Esther White
Address: Willards Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 22, 1947 (month) (day) (year)
Cemetery or crematory: New Hope
Location: Near Willards, Md.
18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.
19. 4/22/47 (Date rec'd by registrar) W. C. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 19 1947 at 2 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1947 to April 19 1947
and that I last saw him alive on April 19, 1947
Immediate cause of death: Coronary Thrombosis — DURATION: 20 minutes
Due to:
Due to:
Other conditions: arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R Lewis M.D. M. D. or other
Address: Willards Md Date signed: 4-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

01492

MV Reg. Dist. No. 260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? three hours fifty minutes
Hospital, Institution, or street address where death occurred:
Penisula General Hospital, Salisbury, MD.
How long in hospital or institution? 3 Hrs 50 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: New Jersey County:
City or town: Spring Lake (If outside city or town limits, write RURAL and give nearest town)
Street No.: 507 6th Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: World War 2. ✓

3.(a) FULL NAME: Daniel Joseph WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W hite	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 27, 1921

8. AGE: Years	Months	Days	If less than one day
26	2	15	hrs. min.

9. Birthplace: Spring Lake, New Jersey (Town, county, and state)
10. Usual occupation: U. S. Navy
11. Industry or business: U. S. Navy

FATHER
12. Name: Daniel F. Williams
13. Birthplace: Little Silver, N. J.

MOTHER
14. Maiden name: Florence Resell (Gilliam T. Roffiell)
15. Birthplace: New Jersey

16. Informant: Daniel F. Williams
Address: 507 6th Ave, Spring Lake Heights, N.J.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Unknown (month) (day) (year)
Cemetery or crematory: Unknown
Location:

18. Funeral director: U.S. Naval Official
Address: Chincoteague, Va.

19. 4/14/47 (Date rec'd by registrar) R.N. Johnson, M.D. g.d. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 19 47 at 1135 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 ..... and that I last saw h... alive on ..... 19 .....

Immediate cause of death	DURATION
Injuries Multiple Extreme	
Due to: Multiple Compound Fractures Internal Injuries, Fractured Skull and Lung Hemorrhage	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Not Performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 4-11-47
Where did injury occur? Route 13, Somerset, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) US Highway 13
Means of injury: Meter Cycle Accident Injured at work? No

23. SIGNATURE: Henry M. Lankford, Jr. HENRY M. LANKFORD, Dep. Dep. Med. Examiner
Address: Princess Ann, Maryland. Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

01493

CERTIFICATE OF DEATH

MV
Reg. Dist. No. 339

1. PLACE OF DEATH
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: U.S. Highway #13 near Salisbury Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Wood st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ruth Frances Williams

3.(b) Social Security Number

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 4- 1927
8. AGE: Years 20 Months 0 Days 22 If less than one day ... hrs. ... min.
9. Birthplace: Salisbury Maryland (Town, county and state)
10. Usual occupation: Student Nurse
11. Industry or business: at P.H. Hospt. Salisbury Md.
FATHER 12. Name: Earl M. Williams
13. Birthplace: R.D. Salisbury Md.
MOTHER 14. Maiden name: Mary L. Nichols
15. Birthplace: R.D. Delmar Md.
16. Informant: Mrs. Mary L. Williams
Address: 115 Wood st. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 29-47 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md.
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland
19. 4/26 (Date rec'd by registrar) H.T. Labrie & E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26th 47 at ... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate 19 to 19 and that I last saw h... alive on ... 19

	DURATION
Immediate cause of death: Fracture of Skull	accident
Due to: Automobile Accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 4/26/47
Where did injury occur? Salisbury Wicomico Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Automobile accident Injured at work? No

23. SIGNATURE Chas. T. Fisher M.D.
M.D. or other
Address Medical Examiners office Salisbury Md. Date signed 4/29/47.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

01494

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic.
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Donald R. Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17. 1946

8. AGE: Years | Months 11 | Days | If less than one day: hrs. ..... min.

9. Birthplace: P.G. Hospital Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Levin R. Wilson
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth V. Dykes
15. Birthplace: Md

16. Informant: Levin R. Wilson
Address: Mardela Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4 19 1947 (mo.) (day) (year)
Cemetery or crematory: Mardela
Location: Mardela, Md.
18. Funeral director: Graveyer Bros
Address: Sharptown, Md.

19. 4/19/47 19 (Date rec'd by registrar) W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/17, 1947, at 7.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1946 to April 1 1947 and that I last saw h..m alive on April 1 1947

Immediate cause of death	DURATION
Cerebral paralysis	congenital
Due to: Congenital heart disease (Lesion not determined)	
Due to: ~~xxx~~	
Other conditions: aplasia of mandible	congenital
Malnutrition and dehydration	all his life

(Include pregnancy within three months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Kines M.D. (M. D. or other)
Address: 221½ Camden Ave. Salisbury. Date signed: 4/17/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

01495

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Hebron
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10years

Hospital, institution, or street address where death occurred:

Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Heborn
(If outside city or town limits, write RURAL and give nearest town)

Street No. Main
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM ROY WILSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cora V. Wilson

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 29, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	27	hrs. min.

9. Birthplace Wetipquin, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation Plants Manufacturing

11. Industry or business

FATHER 12. Name William Henry Wilson

13. Birthplace Wicomico Co. Maryland

MOTHER 14. Maiden name Mary Virginia Waller

15. Birthplace Wicomico Co., Maryland

16. Informant Mrs. Cora V. Wilson

Address Hebron, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/27/47 (month) (day) (year)

Cemetery or crematory Hebron Cemetery

Location Hebron, Maryland

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Maryland

19. 4/28, 1947 Cassie L. Johnson Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24, 1947 at 11:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947 to April 24 1947 and that I last saw h. me alive on April 24 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or Other

Address Helen Md Date signed April 24 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01496

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Fruitland md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION) no

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary H Wright

3. (b) Social Security Number: no

4. Sex: female

5. Color or race: A.A.

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Dulaney Wright dead

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Jan 15 1876

8. AGE: Years: 71 Months: 2 Days: 20 If less than one day: ....hrs. ....min.

9. Birthplace: Snowhill (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER

12. Name: James Anderson

13. Birthplace: Snowhill md

MOTHER

14. Maiden name: Sarah J Parks

15. Birthplace: Snowhill md

16. Informant: Pauline Thompson

Address: Fruitland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 9 1947 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Fruitland Md

18. Funeral director: James H Stewart

Address: Salisbury md

19. 4/19/47 (Date rec'd by registrar) Harriet L Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-5-47 19.... at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-47 19.... to 4-5-47 19....

and that I last saw h.... alive on 4-5-47 19....

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Ida
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Lee L. Laury M.D.

M.D. or other

Address: Fruitland Date signed: 4-6-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01497

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

Reg. Dist. No. 337.

1. PLACE OF DEATH
County Worcester
City or town White Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town White Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Rebecca Young. 3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

6.(b) Name of husband or wife Robert Henry Young
(c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1860

8. AGE: Years 86 | Months 6 | Days 15 | If less than one day ... hrs. ... min.

9. Birthplace Nanticoke Maryland
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name John Parker
13. Birthplace Nanticoke Maryland

MOTHER 14. Maiden name Sarah Lewis
15. Birthplace Nanticoke Maryland.

16. Informant Mr. William Parker Young
Address White Haven Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24 1947 (month) (day) (year)
Cemetery or crematory Turner Cem.
Location Nanticoke Maryland.

18. Funeral director Holloway & C. Walter R. Holloway
Address Salisbury Maryland.

19. 4/23 1947 R. Woolford Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 nd 1947, at 2 10a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 1947, to 22 April 1947, and that I last saw her alive on 22 April 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	5 days.
Due to Hypertensive arterio-sclerotic	5
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard H. Saunders M.D.
M. D. or other
Address Nanticoke Md. Date signed 23 April 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M